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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JANCI MILLER, AKA JANCI BLODGETT** 32452 Apricot Tree Road Winchester, CA 92596 **Registered Nurse License No. 712840** Respondent.	Case No. 2013-948 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about September 20, 2007, the Board of Registered Nursing issued Registered Nurse License Number 712840 to Janci Miller, aka Janci Blodgett (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY AND REGULATORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUGS

10. Dilaudid is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(j) and is a dangerous drug pursuant to Business and Professions Code section 4022. Dilaudid is a trade name of the generic drug hydromorphone and is used to treat pain.

11. Vicodin is a Schedule III controlled substance pursuant to Health and Safety Code section 11055(b)(1)(l) and is a dangerous drug pursuant to Business and Professions Code section 4022. Vicodin is a trade name for the narcotic substance hydrocodone or dihydrocodeinone with the non-narcotic substance acetaminophen.

FACTS

12. At all times relevant to this Accusation, Respondent was a Registered Nurse in the Emergency Department of Palomar Medical Center (hereinafter "Hospital"). Respondent started her employment at the Hospital on June 15, 2009 as a Per Diem Clinical Nurse.

13. On or about March 29, 2010, the Board received a complaint from C.P. alleging that Respondent had a pattern of withdrawing Dilaudid from Pyxis[1] without a physician's order and wasting it a short time later. There were 130 incidents of Dilaudid wasted in the Emergency Department from November 7, 2009 through February 4, 2010. Respondent had 54 of these wastes, which was 42% of the total number of wastes. This was a disproportionate amount of wastage for one nurse. Respondent's variance from the standard deviation was "off the chart." For example, Respondent's withdrawal and wastage pattern was 18.3 standard deviations beyond the predicted norm for January, 2010. Respondent also had a pattern of documenting doses of Dilaudid given in excess of the physician's order or without an order.

14. C.P. reviewed 18 patient charts. The Board's investigation focused on 12 of the 18 patient charts and revealed the following:

A. **Patient #1:** MRN: ---7245:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
11/8/2009	None	2 1-mg Dilaudid @ 0521 hours	None	2 mg Dilaudid @ 0524	No MD orders. No documentation in nurses' notes.

B. **Patient #2**: MRN: ---8363:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
11/10/2009	None	2 1-mg Dilaudid @ 1736 hours	None	2 mg Dilaudid @ 1748 hours	No MD orders. No documentation in nurses' notes.

[1] Pyxis is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. The user is required to enter a second code "PIN" number, similar to an ATM machine, to gain access to medications. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witnessed by another authorized user and is also recorded by the Pyxis machine.

C. **Patient #3**: MRN: ---9120:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
11/16/2009	None	1-mg Dilaudid @ 0433 hours	None	1 mg Dilaudid @ 0451 hours	No MD orders. No documentation in nurses' notes.

D. **Patient #4**: MRN: ---7542:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
12/5/2009	None	1 mg Dilaudid @ 1947 hours	None	1 mg Dilaudid @ 2008	No MD orders. No documentation in nurses' notes.

E. **Patient #5**: MRN: ---6144:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
1/25/2010	None	1 mg Dilaudid @ 2223 hours	None	1 mg Dilaudid @ 2300 hours	No MD orders. No documentation in nurses' notes.

F. **Patient #6**: MRN: ---4540:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
1/27/2010	None	1 mg Dilaudid @ 2142 hours	None	1 mg Dilaudid @ 2153 hours	No MD orders. No documentation in nurses' notes.

G. **Patient #7**: MRN: ---9882:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
2/4/2010	None	1 mg Dilaudid @ 2002 hours	None	1 mg Dilaudid @ 2030 hours	No MD orders. No documentation

					in nurses' notes.

H. **Patient #8**: MRN: ---2325:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
2/5/2010	None	1 mg Dilaudid @ 0355 hours	0.5 mg Dilaudid @0400 hours	0.5 mg Dilaudid @ 0355 hours	No MD orders.

I. **Patient #9**: MRN: ---9867:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
2/4/2010	None	1 mg Dilaudid @ 1946 hours	None	None	1 mg Dilaudid. No MD orders. No documentation in nurses' notes.

J. **Patient #10**: ---9917:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
2/4/2010	None	8 mg Morphine @ 0002 hours	None	8 mg Morphine @ 0026 hours	No MD orders. No documentation in nurses' notes.

K. **Patient #14**: MRN: ---8680:

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
11/13/2009	2 mg Dilaudid	2 1-mg Dilaudid @ 2301 hours	2 mg Dilaudid at 2305 hours	2 mg Dilaudid @ 2011	2 mg Dilaudid-charted in excess of withdrawal.

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L. **Patient #18**: MRN: 5557

Date	Physician's Order	Withdrawn By Respondent	Charted as Given	Wastage Noted	Discrepancy
11/5/2009	1 mg Dilaudid and MR[2] x2	2 mg Dilaudid @ 2055 hours	1 mg Dilaudid @ 0220 hours	2 mg Dilaudid @ 2110 hours	1 mg Dilaudid charted as given, when 2 mg Dilaudid withdrawn and 2 mg Dilaudid wasted at 2110 hours.
11/6/2009		1 mg Dilaudid @ 0142 hours	1 mg Dilaudid @ 0240 hours	1 mg Dilaudid @ 0148 hours	1 mg Dilaudid charted as given when 1 mg Dilaudid withdrawn and 1 mg Dilaudid wasted at 0148 hours
			1 mg Dilaudid @ 0330 hours		None.
			1 mg Dilaudid @ 0400 hours		No physician's order.

15. During the Board's investigation, Respondent's medical records from Dr. P. and her CURES report were obtained. According to the medical records obtained, Dr. P. first prescribed Vicodin to Respondent on November 19, 2009 for back pain. The CURES report shows that Respondent received prescriptions for Vicodin (hydrocodone bitartrate) from July 14, 2009 through April 28, 2010. Respondent received prescriptions for a total of 1150 Vicodin tablets between July 14, 2009 through April 28, 2010. The CURES query occurred on May 17, 2010 and no further CURES information was obtained after May 17, 2010.

FIRST CAUSE FOR DISCIPLINE

(Unlawfully Obtain or Possess Controlled Substances)

16. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), for unprofessional conduct in that Respondent unlawfully obtained or possessed controlled

[2] "MR" means "may repeat."

substances without a physician's order, as more fully set forth in paragraphs 12 - 14 above, and incorporated by this reference as though set forth in full herein.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1) for unprofessional conduct in that Respondent was grossly negligent when she obtained and administered a controlled substance to a patient without a physician's order and failed to account for the controlled substance with accurate, complete, consistent and legible documentation, as more fully set forth in paragraphs 12 - 14 above, and incorporated by this reference as though set forth in full herein. Respondent knew, or should have known, that obtaining, possessing, administering and failing to account for controlled substances could have jeopardized the health and life of patients by exposure to a highly addictive, and potentially harmful medication.

THIRD CAUSE FOR DISCIPLINE

(Falsify, Make Grossly Incorrect and/or Inconsistent Statement in Patient Records)

18. Respondent is subject to disciplinary action under Code section 2762, subdivision (e), for unprofessional conduct, in that Respondent made false, or grossly incorrect, grossly inconsistent, or unintelligible entries in the patient records with regard to the administration and/or wastage of controlled substances, as more fully set forth in paragraphs 12 - 14 above, and incorporated by this reference as though set forth in full herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

19. Respondent is subject to disciplinary action under Code section 2761, subdivision (a) for unprofessional conduct in that Respondent obtained and administered a controlled substance to a patient without a physician's order and failed to account for the controlled substance with accurate, complete, consistent and legible documentation, as more fully set forth in paragraphs 12 - 14 above, and incorporated by this reference as though set forth in full herein.

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DISCIPLINE CONSIDERATIONS

20. On or about May 19, 2011, the Board received an anonymous complaint that alleged Respondent was diverting controlled substances from Kaiser Permanente Hospital in Anaheim. During the Board's investigation, other nurses who worked with Respondent claimed that their patients complained of not feeling the effects of medication when administered by Respondent but did feel relief when the medication was administered by other nurses. The nurses described Respondent as "hyper," looking ashen and pale, and sweating profusely "to the point where sweat was dripping." Respondent was described as cranky early in her shift but after evening break would return "relaxed" and a "different person." Respondent would occasionally stutter. The nurses did not like to witness Respondent's wastage because she held the medication and her body in a way that prevented the witnessing nurses from seeing how much medication Respondent withdrew and the amount wasted. In addition, Respondent reportedly medicated patients who were not assigned to her and without being asked. While Respondent's withdrawals of Dilaudid from Pyxis were above normal use and Dilaudid withdrawals increased when Respondent was on duty, Respondent's charting met Kaiser Permanente's protocol.

21. The Board's retained expert reviewed the allegations pertaining to Respondent's employment at Palomar Medical Center and Kaiser Permanente Hospital. The Board's expert concluded that these two cases "demonstrate the clear and present danger [Respondent] has been to self and the public and remains as such." The expert opined that Respondent's behavior at Kaiser Permanente Hospital is consistent with an on-going pattern of substance abuse.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 712840, issued to Janci Miller, aka Janci Blodgett;

2. Ordering Janci Miller to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: April 22, 2013

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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